reviews

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Poor Health: Social Inequality before and after the Black Report

Eds Virginia Berridge, Stuart Blume

Frank Cass, £17.50, pp 235
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www.frankcass.com

Rating: ★★★★

The most memorable press conference I have ever attended took place in hastily improvised premises behind a guitar shop in Soho, London, in 1987. It had been intended to take place at the nearby Health Education Council, to which I had been hurrying when to my surprise I saw various eminent worthies, including Sir Douglas Black, traipsing towards me with a retinue of journalists. They had been turfed out of the Health Education Council at the last moment when the political implications of the publication they were about to launch suddenly dawned on the council chairman. He hamfistedly tried to distance the organisation from the report at the 11th hour, though his director general had commissioned it a year earlier.

A public relations triumph ensued for the report, *The Health Divide*. It led the television news bulletins that evening, and commanded swathes of space in national newspapers for the rest of the week. The director general of the Health Education Council, Dr David Player, told me gleefully a few days later: "It is going like hot cakes. They were queuing outside in New Oxford Street. We have a bestseller on our hands."

Not bad for what was essentially an academic review of the literature on health inequalities, intended as a follow up to the Black report of seven years earlier. The two were later published together as a Pelican paperback, marketed for a mass readership. They attained cult status, not least because of the irony that the Black report had also experienced apparent attempts at suppression.

Though much work has been done on inequalities since their era—a lot of it inspired directly by them—they remain seminal texts, crucial to understanding a subject which, in the class conscious United Kingdom, is riddled with political nuance. Berridge and Blume's book is in turn an essential guide to understanding how all those nuances affected Black and *The Health Divide*, and resulted in their lasting influence.

History manufactures occasional vignettes that focus the preoccupations of their age, imbuing them with symbolic force. The fate of the Black report was one such. Commissioned by a Labour government in its death throes, delivered to a Conservative one that cared not a jot for the notion of "inequality" and even less for Black's costly recommendations, it revealed as much about contemporary social attitudes and the role of the media as it did about its ostensible subject.

Berridge and Blume explore the mythology that has accreted around the Black report in the 23 years since it was quietly slipped into the public domain on an August bank holiday. The Department of Health had envisaged the report would take about 15 months to complete; it took nearer 30, with team members initially overwhelmed by complex statistical data definitions, issues, and concepts. Patrick Jenkin, the minister forever stigmatised in health circles as the one responsible for its intentionally inauspicious release, has a short chapter to protest his innocence of all guile. He perhaps protests too much. His claim that officials comprehensively rubbished the report is given short shrift by Black team members in a witness seminar transcribed as another chapter—which is a more lively read than you might assume.

At the same event, a senior civil servant of the time told them that if they had produced a "small report with modest recommendations it might have got into Whitehall sufficiently for action." He misses the point. By refusing to compromise and appearing to cock a snook at Thatcher, they got more action than they could ever have expected.

The morals of the story are that governments are most vulnerable when attempting to smother stories in this media age, and bloody minded refusal to trim to prevailing winds can still sometimes ensure your boat comes in eventually.

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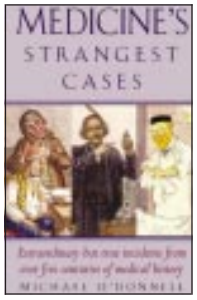
Medicine's Strangest Cases

Michael O'Donnell



Robson Books, £8.99, pp 316
ISBN 1 86105 563 3

Rating: ★★★

This humorous tome by a former doctor, writer, and broadcaster is an enjoyable tour through medical history. It relates sometimes hilariously funny, sometimes barely credible, bizarre, amusing, or mischievous cases and incidents. O'Donnell's source material included his own collection of doctors' letters sent to him when he was editor of *World Medicine* and later when he was a *BMJ* columnist. The result is an amusing hotchpotch of 109 anecdotes, starting with Hippocrates (460-377 BC) and ending in California in 1999, but heavily weighted towards the 20th century.

Famous historical figures, such as English country doctor Edward Jenner, intermingle with less well known ones, such as Dorset farmer Benjamin Jesty, "The Man whom History Passed by." Jenner wrongly became famous for performing the first vaccination (for cowpox, inducing immunity to smallpox) because Jesty actually beat him to it, saving his wife and sons by scratching their arms with a stocking needle that he had contaminated by pricking it into an infected cow's udders.

"The Surgical Triple Whammy" tells the story of 19th century Scottish surgeon Robert Liston, who became famous for the great speed at which he amputated limbs. After performing the first amputation under anaesthesia in 1846, when he severed a leg "in his usual two and a half minutes," he commented on the new technique: "This Yankee dodge beats mesmerism hollow."

"Striving Inofficiously" describes the death of England's King George V, who received a lethal injection of morphine and cocaine from his doctor, Lord Dawson, who had agreed with the queen not to "strive officiously" to keep the king alive. Dawson then proceeded to oppose a bill enabling euthanasia in the House of Lords, arguing that legislation was unnecessary because "good doctors" already helped their patients to die.

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Spin doctors soft pedal data on antihypertensives

The results of a major study that compared different classes of antihypertensives have drug company spin doctors working overtime. It's no easy job to save market share for expensive antihypertensive drugs when headlines read "When Cheaper Is Also Better," as one did in the *New York Times* on 19 December 2002.

The "antihypertensive and lipid lowering to prevent heart attack trial" (ALLHAT), published in the 18 December issue of *JAMA* (2002;288;2981-97), shows that calcium channel blockers and angiotensin converting enzyme (ACE) inhibitors used to treat hypertension were no better than a diuretic. In some instances they were not quite as safe—even though they were substantially more expensive.

But the spin doctors are swinging into action to counter the clear message of ALLHAT that cheaper is better, even if that means just playing it down. Kevin Brode, vice president of sales and marketing at marketRx, a firm that provides strategic marketing information to the pharmaceutical industry, isn't too worried about who the winner will be. "Doctors say they'll change their prescribing habits after a negative study," he said, "but their prescription behaviour tends not to bear this out."

Why not? "The reality is no one promotes a diuretic," said Mr Brode. "So you've got one study that says yes, you should [use a diuretic], then starting the day after, you've got a $10bn [£6.2bn; €9.5bn] industry . . . and 55 promotional events . . . for an ACE inhibitor coming back in and saying 'Here's why my ACE inhibitor is safe and here's why you should be using this.' I mean, it's promotion. Can ALLHAT stand up to that?"

Mr Brode, despite his rosy predictions regarding sales, didn't challenge the ALLHAT results, saying instead: "Great data. Very solid. Didn't surprise anybody . . . but nobody's promoting diuretics."

But if Dr Curt Furberg, chair of the ALLHAT steering committee, has his way, that won't be the case. He and other ALLHAT staff are staying on to disseminate the data. He says that expensive calcium channel blockers and ACE inhibitors may be costing an excess of $8bn to $10bn—without providing any benefit to patients, and in some instances adding more risk.

Why was so much money wasted for so many years on drugs that weren't as good? Dr Furberg says, "We just didn't know." But why didn't they know?

The practice of testing new medicines against placebo, rather than against the best treatment available, has contributed to a general lack of knowledge. But spin doctoring clearly triumphed when a head-to-head comparison provided at least one answer. In March 2000 the ALLHAT researchers halted the α blocker arm of the trial when it was found that doxazosin (Cardura) was inferior to a diuretic. Patients on Cardura, dubbed a "miracle drug" by a Pfizer executive, experienced a 25% higher rate of cardiovascular disease and twice the rate of congestive heart failure as patients on a diuretic, results published in the 19 April 2000 issue of *JAMA* show.

Pfizer, aware of the results before publication, launched a sophisticated damage control campaign in early 2000. Sales of Cardura, estimated at $800m (£500m;€760m) worldwide in 2000, continued virtually unaffected by the study for the rest of the year.

Just how Pfizer managed this feat is revealed by internal drug company documents filed in January 2001 as part of a "citizen's petition" against Pfizer. The plan included using an outside research agency to study doctors' awareness of the ALLHAT results. When the agency found that "knowledge of the trial's preliminary results is minimal for all specialties," they took steps to avoid sullying that lack of awareness.

Pfizer decided not to issue a public statement about the ALLHAT results because doing so "would likely draw more media attention to the situation." They instructed their drug reps to provide information about ALLHAT "only when asked." Finally, two enterprising Pfizer employees were praised as "quite brilliant" for "sending their key doctors to sightsee" during a presentation at the annual American College of Cardiology conference in California in 2000. The doctors, from Italy, were brought to California by Pfizer. The tour, according to the Pfizer email praising the reps, kept the doctors from attending Dr Furberg's presentation of the ALLHAT results.

But Pfizer was not alone in blunting the response to ALLHAT results. The American College of Cardiology (ACC) issued an alert in March 2000 urging doctors to "discontinue use" of Cardura. However, another Pfizer memo dated 28 March 2000 and stamped "confidential" says that Pfizer was "successful in getting the ACC to agree to a clarification" of the ACC press release. The "clarification" that the ACC agreed upon replaced its initial press release on the ACC website within just hours of the original posting and changed the recommendation that Cardura be discontinued to a much milder recommendation that doctors "reassess" its use. It may have added to Pfizer's standing with the ACC that Pfizer has contributed more than $500 000 (£312 000; €474 000) annually to the college in recent years.

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A longer version of this article is available on bmj.com

WEBSITE OF THE WEEK

Childcare for working parents In this week's *BMJ* soap opera (see career focus p s23), Penelope Millstone, the pregnant, workaholic medical senior house officer, is arguing with her general practitioner husband, Giles Millstone, over whether she should work full or part time after their baby is born. Giles wants her to "concentrate on motherhood" but consents that she can work part time "once the baby is old enough." Penelope is adamant that she wants to work full time as she plans to have an academic career. Sound familiar?

So what resources can help families in this situation? The Daycare Trust (www.daycaretrust.org.uk) for one. This charity states that it promotes "high quality affordable child care for all." It provides detailed information, facts, and figures. For example, in its publication *Childwise* (which you can download) it states that 40% of big employers say that childcare problems prevent female staff from returning to work after maternity leave.

How different from the Swedish situation where life is made so much easier for parents. For example, after the birth of a child, parents can draw parental benefit for 450 days to stay away from work and look after their child. The English version of all the benefits Swedes are entitled to can be downloaded (www.fk.se). It is a real eye opener.

To be fair, the British government is trying to bring about some changes for doctors through the improving working lives campaign, (www.doh.gov.uk/iwl), which includes childcare provision. Seemingly, "by April 2003, all NHS staff should have access to a childcare co-ordinator who will be able to provide them with childcare advice and options," says the Improving Working Lives for Doctors policy lead (www.bmj.com/cgi/content/full/325/7356/S17a).

Of course, there are many private companies in cyberspace touting for business, such as the American www.childcare.net where members (you can join free online) have access to a mine of information and a chance to ask crucial questions such as: "Do you give your childcare provider a gift for the holidays? And if so, what do you give her and how much do you generally spend?" Not being a member, I couldn't access the answer. Sadly.

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PERSONAL VIEW

The second gasoline war and how we can prevent the third

War in Iraq is inevitable. That there would be war was decided by north American planners in the mid-1920s. That it would be in Iraq was decided much more recently. The architects of this war were not military planners but town planners. War is inevitable not because of weapons of mass destruction as claimed by the political right, nor Western imperialism as claimed by the left. The cause of this war, and probably the one that will follow, is car dependence.

The United States has paved itself into a corner. The physical and economic infrastructure of the United States is so highly car dependent that it is pathologically addicted to oil. Without billions of barrels of precious black sludge being pumped into the veins of the US economy every year, the nation would experience painful and damaging withdrawal.

The first Model T Ford rolled off the assembly line in 1908 and was a miracle of mass production. In the first decade of the new century, car registrations in the United States increased from 8000 to almost 500 000. Within the cities buses replaced trams, and then cars replaced buses. In 1932 General Motors bought and then closed down the tram system. But it was the urban planners who really got America hooked. Car ownership offered the possibility of escape from dirty crowded cities to leafy garden suburbs and the urban planners provided the escape routes.

Throughout the 1920s and 1930s, America "road built" itself into a nation of home owning suburbanites. Public transport rallied temporarily during the second world war, when car makers switched to making munitions and petrol rationing was introduced, but for the last time. At the end of the war, energy conservation turned to consumption. Cities like Los Angeles, Dallas, and Phoenix were moulded by the private passenger car into vast urban sprawls with such widely dispersed markets that it is now almost impossible to service them economically with public transport.

As the cities sprawled, the motor manufacturing industry consolidated. Car making is now the main industrial employer in the world, dominated by five major groups of which General Motors is the largest. The car makers forged both the livelihood and landscape of north Americans.

Motor vehicles are responsible for about a third of global oil use but for more than half of oil use in the United States (www.wri.org/wri/climate). In the rest of the world, heating and power generation account for most oil use. The large increase in oil prices during the 1973 Arab oil embargo encouraged the substitution of oil with other fuels in heating and power generation, but in the transport sector there is little scope for oil substitution in the short term. Because of artificially low oil and gasoline prices that did not reflect the true social costs of their production and use, there was little incentive to seek alternative energy sources in the transport sector. US transport is now almost totally dependent on oil and supplies are running out.

Suburban America needs oil and Saddam Hussein is sitting on it. The US economy needs oil like a junkie needs heroin and Iraq has 112 billion barrels, the largest supply in the world outside Saudi Arabia. Even before the first shot has been fired, there have been discussions about how Iraq's oil reserves will be carved up. All five permanent members of the United Nations Security Council have international oil companies that have an interest in regime change in Baghdad.

> The United States has paved itself into a corner

Car dependence is a global public health issue of which gasoline wars are only one facet. Every day about 3000 people die and 30 000 people are seriously injured on the world's roads in traffic crashes. More than 85% of the deaths are in low and middle income countries, with pedestrians, cyclists, and bus passengers bearing most of the burden. Most of the victims will never own a car, and many are children. That we accept this carnage as the collateral damage in a car based transport system indicates the strength and pervasiveness of car dependency.

Car use and the corresponding decline in physical activity is an important cause of the obesity epidemic in the United States and the United Kingdom, and physical inactivity increases the risks of heart disease, diabetes, osteoporosis, and hypertension (*BMJ* 1998;316:242-3). Car based shopping has turned many small towns into ghost towns and has severed the supportive social networks of community interaction.

The first gasoline war was waged in Kuwait and the second will be waged in Iraq. The world must act now to prevent the third. We must reclaim the streets, promote walking and cycling, strengthen public transport, oppose new road construction, and pay the full social cost of car use. We must advocate for land use policies that reduce the need for car travel. We need "urban villages" clustered around public transport nodes, not sprawling car dependent conurbations. We can all play our part and we must act now.

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SOUNDINGS

Challenge and change

Here in Auchendreich, far removed from the frenetic pace of events common in the great teaching centres, we pride ourselves on taking the longer view. This is in part a feature of the innate stolidity of the semi-rural Scot, and in part a matter of evidence based realism: our flagship new hospital, opened only last May, was, after all, in its planning stages for more than 30 years.

So at all levels there is recognition that it takes time to achieve real change in complex healthcare systems, and our chief executive's rather low key new year message acknowledged this.

Few were surprised to learn that DreichNet 2000, our long awaited area-wide total IM&T solution—offering real-time clinical imaging facilities, management level videoconferencing, and airline style booking systems even for our most remote psychogeriatric day hospital—is not now expected to go live much before mid-2005.

The imminent departure of our area head of IT to a challenging new role with the betting industry, and the still unexplained disappearance of her former live in partner—upon whose software company the whole system depended—should, the chief executive explained, be seen positively: a real opportunity to step up the momentum of the project, currently being overseen on a part time basis by Miss MacPherson, formerly chief records officer with the old Auchendreich Healthcare Trust, who has kindly agreed to postpone her retirement for at least six months.

IT apart, there were one or two points in the new year message that gave grounds for concern. A new finance director, an exiled Scot working somewhere in England, will not now be joining us, having been offered a greatly improved package by his current employer.

On a more positive note, our deputy medical director, recently promoted to a post in the west that will allow him to spend more time with his 10 metre ocean racer, is to be replaced by an innovative job share involving a consultant and a general practitioner: a widely hailed and progressive appointment, which will become effective as soon as issues arising from their contemporaneous and unexpectedly prolonged maternity leave can be resolved. But as our chief executive put it, up-scaling both our flexibility and our productivity will be key to success in the Greater Auchendreich Health Board Area in the year 2003.

Colin Douglas *doctor and novelist, Edinburgh*